STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E594	A. BUILDING 00 B. WING	08/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCGIVNEY HEALTH CARE CENTER	2907 E 136TH ST CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00114854. Complaint IN00114854 - Substantiated. Federal/state deficiencies related to the allegation are cited at F223 and F225. Survey dates: August 27 & 28, 2012 Facility number: 000545 Provider number: 15E594 AIM number: 100267350 Survey team: Christi Davidson, RN-TC Census bed type: NF: 28 Total: 28 Census payor type: Medicaid: 24 Other: 4 Total: 28 Sample: 3 Supplemental sample: 1 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on August 29,	F0000	McGivney Health Care Centerdoes not believe and does not admit that any deficiencies existed, before or after the survey. McGivney reserves all rights to contest the surveyfindings through informal dispute resolution, formaal appeal proceedings or any administrative or legal proceedings. This plan of correctionis not meant to establish any standard of care, contraact obligatoin or poistion and reserves all rights to raise all possible contentions and defenses in a ny types of civil or criminal claim, action or proceeding. Nothing contained in the plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which McGivney offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality care to residents.McGivney Health Care Center reserves the right to modify polices and/or procedures and quality improvement systems as necessary to better meet the needs of the residents and the facility.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	2012 by Bev Faulkner, RN			

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F0223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure a resident was free from mental and verbal abuse from a facility Licensed Practical Nurse [LPN] #1 and free from physical abuse from another resident for two of four facility allegations of abuse reviewed. (#F) Findings include: The record for Resident #F was reviewed on 8/28/12 at 11:35 a.m. Diagnoses included but were not limited to vascular dementia, bipolar disorder and depression. A nurses note, dated 7/16/12, untimed, indicated Resident #F was alert to self, had short and long term memory problem and wandered. A care plan dated with a last review date of 2/17/12 indicated, "...impaired verbal communication R/T [related to]	F0223	Resident F currently has no recall of said event.No other residents were affected by this pracitce.the Nurse in question was immediately placed suspension and taken off the schedule. On 8/28/2012 said nurse was terminated.Resident F was discharged on 8/29/2012The Facilities Abuse Policy and Procedure was reviewed. All staff are responsible to stop abuse and report abuse immediately.An all staff in-service was conducted by SSD on 8/29/2012 in regards to MHCC Abuse Prevention Policy and Procedure.All new employees will receive and be in-serviced on the MHCC Abuse Prevention Policy and Procedure upon hire.In the event of any Unusual Occurance, the Administrator will be notified immediately after allegation of abuse occurs.The Administrator or designee is the Abuse Investigation Coordinator and will be responsible for the oversight of timely reporting any alleded allegations.All allegations will be submitted via voicemail through	09/27/2012

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	dementia...." A care plan dated with a last review date of 2/17/12 indicated, "...limited in...socialization abilities D/T [due to] inability to recall...." During the entrance conference on 8/27/12 at 9:30 a.m., the DoN was requested to provide any allegations of abuse that had been reported by staff and investigated for the months of June, July and August 2012. On 8/27/12 at 11:00 a.m., four facility reported incidents involving abuse allegations were provided by the DoN. An "Investigative Report for Suspected Abuse, Neglect, or Unusual Occurrence (sic)," dated 6/27/12 at 7:10 p.m., indicated, Resident #F was hit by her roommate. The report indicated Resident #F was interviewed and indicated, "...Resident states roommate (sic) was cussing her and struck her. Resident could not determine where she had been struck. Assessed no reddned (sic) areas noted...[name of roommate] was upset regarding incontinent episode of roommate (sic)...Res [resident] stated 'I hit her'...Resident was assessed...." The report indicated there were no other witnesses and the residents were		the ISDH voicemail reporting system and reviewed per Administrator or designee with each report and then followed with an email or fax with the fax confirmation to the ISDH within 24 hrs of alleged event.TheQuality Assurance Committee will monitor compliance of the facility MHCC Abuse Prevention Policy and Procedure for each incident and on a quarterly basis.Compliance to be obtained by 9/27/2012	

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	separated. During the initial tour on 8/27/12 at 9:35 a.m., Resident #F did not have the roommate listed in the abuse allegation, dated 6/27/12. An "Investigative Report for Suspected Abuse, Neglect, or Unusual Occurrence (sic)," dated 8/20/12 at 6:00 p.m., indicated, "...Name of Resident(s): [Name of Resident #F]...Resident was told/taken to sit at a separate table in the dining room [sign for and] was positioned to face the wall after warning the resident that if she did not sit down that she would sit in the corner...[name of Resident #F] stated that the nurse was mean and made her sit at the table [sign for with] people that cannot feed themselves [sign for and] also later made her sit by herself facing the wall...The nurse was suspended during the investigation...." A handwritten statement, included in the investigation for the incident, dated 8/20/12 involving Resident #F, dated 8/23/12 and signed by CNA #2 indicated, "On Monday August 20 during dinner I witnessed the charge nurse yell at and count to 3 for [name of Resident #F] to sit down. She told [name of Resident #F] that if she didn't sit down by the time she got to 3 she was going to sit in the			

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	corner...the charge nurse sat her in the corner facing the wall...but the nurse forced her to sit." A handwritten statement undated, untimed, included in the investigation for the incident dated 8/20/12 involving Resident #F was signed by CNA #3. The statement indicated, "...the nurse then told Resident if she gets up again she will have to sat (sic) with the feed resident...the nurse put her at the feed table...the nurse made her sit alone and face the wall." A type written statement, dated 8/23/12, with the typed name of LPN #1, included in the investigation for the incident dated 8/20/12 involving Resident #F indicated the LPN's recall of August 20, 2011(sic) at 4:30 p.m. The statement indicated, "...Never once was the resident forced to sit anywhere other than her choice of seating...Again she was asked to sit down by staff. This only lasted a few minutes and she would be up again...She was asked to sit down again repeatedly...Once back in the dinning (sic) room at the med cart, [name of Resident #F] again came into the room and asked for a chair. I said no, and reminded her nurses would be there momentarily to give report. [name of Resident #F] directed her attention to [name of staff member] and asked her,			

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	[name of staff member] had just arrived and didn't know she had been told no chair; she began to pull the chair into the hall. I did speak in a higher than normal voice due to frustration says (sic) 'No, pauses No, you were told no chair until report was over.'...I agreed to give report over the phone, thinking that I was the one her behavior was directed towards...At that time I left the property." A Facility Incident Report indicated, "...Incident Date: 08/20/12...Resident Name: [Resident #F]...Staff Involved: [LPN #1]...Reported that nurse sat resident down in dining room in a chair by herself facing the wall after resident had many request for various things...Resident states nurse was mean to her...The nurse has not worked since (sic) the date of the incident allegedly occurred and has been suspended pending investigation...The nurse will be terminated this date of 08/28/12...[an x marked in the box for] Follow-up Report...." During an interview on 8/27/12 at 11:40 a.m., the DoN indicated, LPN #1 would be terminated based on the results of the facility investigation. The DoN indicated LPN #1 did not work any other shifts past 8/20/12 when she left the building.			

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	A facility policy provided by the DoN on 8/27/12 at 1:25 p.m., titled, "MHCC [McGivney Health Care Center] Abuse Policy and Procedure (June 2012), indicated, "Policy: It is the mission of this facility to provide its residents with a safe and pleasant environment in which to live...The facility will not tolerate verbal, mental, sexual or physical abuse, corporal punishment or involuntary seclusion, nor will it allow any staff member to punish a resident at any time during a resident's stay in this facility...Physical Abuse-includes,...Resident to resident abuse with or without injury...Verbal Abuse-is defined as...belittling residents...Mental Abuse-includes...humiliation...threats of punishment...." This Federal tag relates to Complaint IN00114854. 3.1-27(a)(1) 3.1-27(b)			

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F0225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the	F0225	Resident C, D, and F currently	09/27/2012

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	facility failed to report an allegation of staff to resident abuse and an allegation of resident to resident abuse immediately to the Administrator and to the state agency, ISDH [Indiana State Department of Health], for 2 of 4 facility allegations of abuse incidents reviewed. (Residents #C, #D, #F) Findings include: 1. During the entrance conference on 8/27/12 at 9:30 a.m., the DoN was requested to provide any allegations of abuse that had been reported by staff to the Administrator and investigated for the months of June, July and August 2012. On 8/27/12 at 11:00 a.m., four facility reported incidents involving abuse allegations were provided by the DoN. An "Investigative Report for Suspected Abuse, Neglect, or Unusual Occurrence (sic)," dated 8/20/12 at 6:00 p.m. indicated, "...Name of Resident(s): [Name of Resident #F]...Resident was told/taken to sit at a separate table in the dining room [sign for and] was positioned to face the wall after warning the resident that if she did not sit down that she would sit in the corner...[name of Resident #F] stated that the nurse was mean and made her sit at the table [sign for with] people		have no recall of said event.No other residents were affected by this practice. The Nurse in question was immediately placed on suspension and taken off schedule. On 8/28/2012 said nurse was terminatedResident F was discharged on 8/29/2012The Facilities Abuse Policy and Procedure was reviewed. All staff are responsible to stop abuse and report immediately.An all staff in-service was conducted by SSD on 8/29/2012 in regards to MHCC Abuse Prevention Policy and Procedure.All new employees will receive and be in-serviced on MHCC Abuse Prevention Policy and Procedure upon hire.In the event of an Unusual Occurance, the Administrator will be notified immediately after allegation of abuse occurs.The Administrator or designee is the Abuse Investigation Coordinator and will be responsible for the ovesight of timely reorting any alleged allegation.All allegations will be submitted via voicemail through the ISDH voicemail reporting system and reviewed per administrator or designee with each report and then followed with an email or fax confirmation to the ISDH within 24 hrs. of alledged eventthe Quality Assurance Committee will monitor compliance of the facility MHCC Abuse Prevention Policy and Procedure for each incident and on a quarterly basis.Compliance to be obtained	

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	that cannot feed themselves [sign for and] also later made her sit by herself facing the wall...The nurse was suspended during the investigation...." A handwritten statement, included in the investigation for the incident, dated 8/20/12, involving Resident #F, dated 8/23/12 and signed by CNA #2 indicated, "On Monday August 20 during dinner I witnessed the charge nurse yell at and count to 3 for [name of Resident #F] to sit down. She told [name of Resident #F] that if she didn't sit down by the time she got to 3 she was going to sit in the corner...the charge nurse sat her in the corner facing the wall...but the nurse forced her to sit." A handwritten statement undated, untimed, included in the investigation for the incident, dated 8/20/12, involving Resident #F was signed by CNA #3. The statement indicated, "...the nurse then told Resident if she gets up again she will have to sat (sic) with the feed resident...the nurse put her at the feed table...the nurse made her sit alone and face the wall." A type written statement, dated 8/23/12, with the typed name of LPN #1, included in the investigation for the incident dated 8/20/12 involving Resident #F indicated		by 9/27/2012	

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	the LPN's recall of August 20, 2011(sic) at 4:30 p.m. The statement indicated, "...Never once was the resident forced to sit anywhere other than her choice of seating...Again she was asked to sit down by staff. This only lasted a few minutes and she would be up again...She was asked to sit down again repeatedly...Once back in the dinning (sic) room at the med cart, [name of Resident #F] again came into the room and asked for a chair. I said no, and reminded her nurses would be there momentarily to give report. [name of Resident #F] directed her attention to [name of staff member] and asked her, [name of staff member] had just arrived and didn't know she had been told no chair; she began to pull the chair into the hall. I did speak in a higher than normal voice due to frustration says (sic) 'No, pauses No, you were told no chair until report was over.'...I agreed to give report over the phone, thinking that I was the one her behavior was directed towards...At that time I left the property." A Facility Incident Report indicated, "...Incident Date: 08/20/12...Resident Name: [Resident #F]...Staff Involved: [LPN #1]...Reported that nurse sat resident down in dining room in a chair by herself facing the wall after resident had many request for various things...Resident states nurse was mean to			

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	her...Nurse has not worked since the date of the incident allegedly occurred and has been suspended pending investigation. This was not reported to the DON until 08/23/12. The staff member was immediately inserviced about reporting immediately to supervisor and inservice is set up for staff...." 2. An "Investigative Report for Suspected Abuse, Neglect, or Unusual Occurrence (sic)," indicated, "Date and Time of Occurrence: July 18, 2012 12:00 noon Reported July 20, 2012 [sign for at] 7:30 a.m. by family. Name of Resident(s): [Resident #C]...Interview with Witness... [name of CNA #4] -[Resident #D] swatted no contact...." A handwritten statement signed by CNA #4 indicated she was present in the dining room on July 18 and overheard Resident #D tell Resident #C she was going to slap her. During an interview on 8/27/12 at 11:40 a.m., the DoN indicated the facility staff had been retrained and inserviced on the importance of reporting all incidents of abuse and all allegations of abuse immediately. The DoN indicated the incident which occurred on 8/20/12 was not reported to ISDH until 8/24/12. The DoN indicated the incident was reported,			

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	"a little over 24 hours" from when she was made aware of the incident on 8/23/12. An ISDH incident report form accompanied the investigation from the July 18, 2012 incident, but there was not a time or date to verify when it was reported to the state agency. During an interview on 8/28/12 at 9:30 a.m., the DoN indicated that ISDH had never received the report of the incident from 8/20/12 that was indicated by the DoN as reported on 8/24/12. The DoN did not have documentation of a fax transmittal on either of the above incidents that were indicated as reported to ISDH. The DoN indicated she was not aware the reports had not been transmitted to ISDH. The DoN indicated an information technologist would evaluate the facility fax machine. The incident from 8/20/12 was sent via telephone with ISDH staff on 8/27/12 and resubmitted via fax on 8/28/12 after two attempts. A Communication Result Report dated 8/28/12 at 8:29 a.m., indicated 3 pages were sent with result "ok" to ISDH. A facility policy provided by the DoN on 8/27/12 at 1:25 p.m., titled, "MHCC [McGivney Health Care Center] Abuse Policy and Procedure (June 2012),			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E594	A. BUILDING 00 B. WING	08/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCGIVNEY HEALTH CARE CENTER	2907 E 136TH ST CARMEL, IN 46033

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	indicated, "Policy: It is the mission of this facility to provide its residents with a safe and pleasant environment in which to live...The facility will not tolerate verbal, mental, sexual or physical abuse, corporal punishment or involuntary seclusion, nor will it allow any staff member to punish a resident at any time during a resident's stay in this facility...Physical Abuse-includes,...Resident to resident abuse with or without injury...Verbal Abuse-is defined as...belittling residents...Mental Abuse-includes...humiliation...threats of punishment...All staff are to immediately stop abuse. Immediately report all all (sic) alleged violations involving mistreatment, neglect, or abuse...are reported immediately to the Charge Nurse. The Charge Nurse is to immediately report abuse to the DON...The DON immediately reports all violations to administrator of the facility and to other officials in accordance with State law...MHCC Administrator/designee will be responsible to complete a REPORTABLE UNUSUAL OCCURRENCE (sic) form within 24 hours of occurrence and send to the ISDH all alleged violations and all substantiated incidents to the state agency and to all other agencies as required...." This Federal tag relates to Complaint			

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